

Wayne County Medicare Stipend Retiree Group MAPD PPO Benefits

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.



Y0074_GrpPPO24G2GOnbrd_M FVNR 0623

Agenda

- Medicare basics
- Getting started
- Group plan benefits
- Prescription drugs
- Health & well-being programs



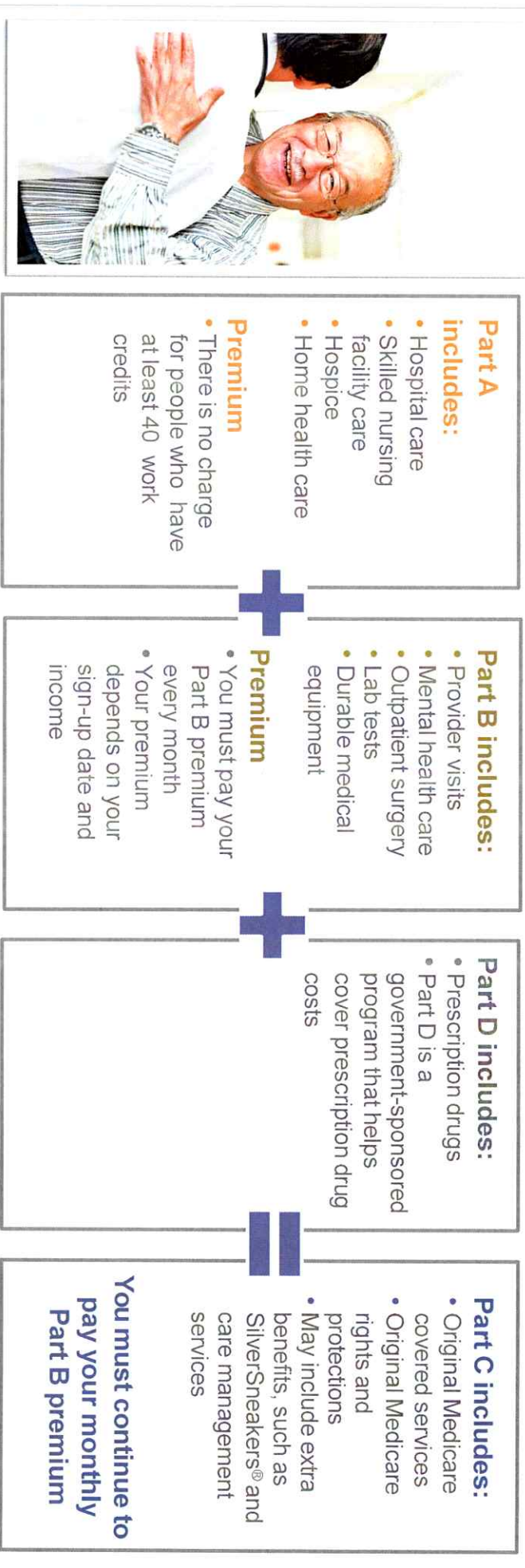
Medicare basics



Medicare basics



A Medicare Advantage plan (Part C) gives you complete coverage.



Getting started with your PPO plan



Understanding your enrollment materials



Medicare-eligible retirees can expect to receive the following materials as part of the pre- and post-enrollment opt-in process.

Pre-enrollment documents



Benefits-at-a Glance



Opt-in form

Post-enrollment documents



Welcome letter



Evidence of Coverage






Resource Guide

Membership confirmation and ID card



Put your red, white and blue Medicare card in a safe place – you only need your Blue Cross member ID card for medical services and prescription drugs.

 Blue Cross Blue Shield of Michigan		Medicare PLUS BlueSM Group PPO	
Enrollee Name VALUED CUSTOMER		Plan H6572_801	
Enrollee ID XYL918888888		RxBIN 610011 RxPCN CTRXMEDD RxGRP BCBSMAN	
Health Plan (80840) 9101003777		Issued 01/2023	
Group Number XXXXX		 MedicareRx <small>Prescription Drug Coverage</small>	

Members: bcbsm.com/medicare		Providers: bcbsm.com/provider/ma	
			
Blue Cross Blue Shield of Michigan <small>A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association</small>			
<small>Use of this card is subject to terms of applicable contracts, conditions and user agreements. Medicare limiting charges apply. Out-of-state providers: file with your local plan.</small>		<small>Misuse may result in prosecution. If you suspect fraud, call: 888-650-8136</small>	
Michigan health providers bill: BCBSM - P.O. Box 32593 Detroit, MI 48232-0593		<small>To locate participating providers outside of Michigan:</small>	
Mail pharmacy claims to: P.O. Box 650287 Dallas, TX 75265		Member Services: 866-684-8216 TTY/TDD: 711	
<small>Provider inquiries:</small> 800-676-BLUE		<small>Facility Prenotification:</small> 800-572-3413	
<small>Rx Prior Authorization:</small> 800-437-3803		<small>VSP - Vision:</small> 800-877-7195	
<small>Dental Servicing:</small>		888-826-8152	

When we'll contact you

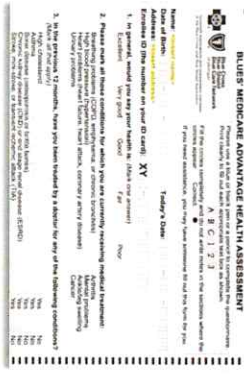


Welcome call and new ID card

Health assessment; we'll remind you to schedule your annual exam and connect to member programs

Coordination of Benefits of Benefits survey

Offer preventive care that can help reduce your out-of-pocket and overall health care costs and share benefits for the upcoming year



COMBINATION OF BENEFITS QUESTIONNAIRE

Please use for reporting benefits from a 1st plan that is not the primary or second plan. Do not use for reporting benefits from a 2nd plan that is the primary or second plan.

Print in complete capital letters. Do not use abbreviations or initials. Do not use "None" or "N/A".

1. Are you and/or the other plan member currently receiving any other health coverage? YES NO

2. If YES, please provide the name of the other plan member and the name of the other plan. Do not include the name of the other plan member if the other plan is a self-insured plan.

3. How long has the other plan member been receiving the other plan? (Date)

4. How long has the other plan member been receiving the other plan? (Date)

5. How long has the other plan member been receiving the other plan? (Date)

6. How long has the other plan member been receiving the other plan? (Date)

7. How long has the other plan member been receiving the other plan? (Date)

8. How long has the other plan member been receiving the other plan? (Date)

9. How long has the other plan member been receiving the other plan? (Date)

10. How long has the other plan member been receiving the other plan? (Date)



Note: A program representative from Blue Cross may call to tell you about additional health programs available in the plan. If you want to verify the call, contact our Customer Service team.

Wayne County Medicare Stipend Retiree Group PPO plan benefits



Key terms



Deductible?

Deductible

The amount you pay before your plan begins to pay its share



Copayment

Fixed dollar amount you pay to health care providers each time you use their services, such as an office visit



Coinsurance

The percentage of the cost of the service that you pay



Out-of-pocket maximum

The most you must spend for copays, coinsurance and deductibles in any given year

Overview of plan benefits



	In and Out of network*
Annual deductible per member per year	\$200 In network and out of network combined
Coinsurance	20% coinsurance
Out-of-pocket maximum for deductible and coinsurance amounts for Medicare-covered medical services, per member per year	\$1,200 In network and out of network combined

Out-of-network/noncontracted providers are under no obligation to treat Medicare Plus Blue members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including out-of-pocket costs that apply to out-of-network services.

Overview of plan benefits



	In and Out of network
Office visits	\$20 copay
Specialist visits; no referral required	\$20 copay
Chiropractic manipulations	\$20 copay
Emergency care	\$100 copay (copay waived if admitted)
Urgent care	\$20 copay
Ambulance services, if medically necessary	Deductible, 20% coinsurance apply

Durable medical equipment, or DME



Medical

- You have coverage for durable medical equipment, such as prosthetics, orthotics and supplies.
- DME, such as canes, walkers, wheelchairs, braces and artificial limbs as well as diabetic therapeutic shoes or inserts are provided through Northwood.

Diabetic

- Diabetes monitoring supplies, including insulin pumps, blood glucose monitors, test strips and lancets are provided through Northwood. Your doctor will write a prescription for you.
- Call Northwood Customer Service at **1-800-667-8496**. Prior authorization rules may apply.

Northwood Inc. is an independent corporation providing durable medical supplies to Blue Cross Blue Shield of Michigan members.

Prior authorization programs



Prior authorization for medical services is one way health plans make sure you receive high-quality care as you and your provider develop a personalized treatment plan.

It may be necessary for your provider to have Blue Cross approve certain services in your treatment plan.

If a request for service isn't approved, you and your provider will both receive a letter detailing the rationale and the process to request reconsideration (appeal), if needed.

Finding a provider



Medicare Advantage PPO providers



PPO means preferred provider organization, with **in-network** or **out-of-network** benefits.

You have freedom to choose any provider, specialist or hospital that accepts Medicare.

Referrals **aren't** required.

In-network and out-of-network member out-of-pocket costs are the same with a passive plan.

In network

Identifies a Medicare provider who has a contractual agreement to be a part of the Blue Cross Blue Shield Medicare Advantage PPO Network.

Out of network

Identifies a Medicare provider who hasn't contracted to be a part of the Blue Cross Blue Shield Medicare Advantage PPO network.

How to find a participating provider



During your welcome call, the representative can check to see if your current provider accepts Medicare Plus Blue Group PPO. If your provider **doesn't** accept Medicare Plus Blue, the representative will help you select a provider who accepts your plan.

Call the Customer Service number on the back of your member ID card (TTY users, call **711**) or visit www.bcbsm.com/medicare and click *Find a Doctor*.

Ask the billing department of your provider's office if they participate with the Medicare Advantage PPO plan offered by Blue Cross.

Download the BCBSM mobile app. It's available in the App Store® for iPhones and Google Play™ for smartphones using Android. Search for "BCBSM."

Apple is a trademark of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries. Google Play is a trademark of Google LLC.

When you travel



Your benefits travel with you anywhere in the U.S. and its territories.

There are two ways to find a provider:

- Use the **Find a Doctor** button in the app.
- Call the number on the back of your ID card.

When traveling outside the U.S., there may be instances where you will need to initially pay for your emergency or urgent care. However, know that you can submit for reimbursement.



**You're covered for
emergency and
urgent care
worldwide**

Virtual Care

We offer safe and secure online medical and behavioral health services through your phone, tablet or computer from anywhere in the U.S.

Virtual Care offered through Teladoc Health® has 24/7 access to U.S. board-certified medical providers trained in telemedicine to treat non-emergency illnesses. Behavioral health services are available by appointment from 7 a.m. to 9 p.m. seven days a week.



Ways to access Virtual Care

Download the Teladoc Health app

Visit [bcbsm.com/virtualcare](https://www.bcbsm.com/virtualcare)

Call **1-800-TELADOC (1-800-835-2362)**

TTY: **1-855-636-1578**

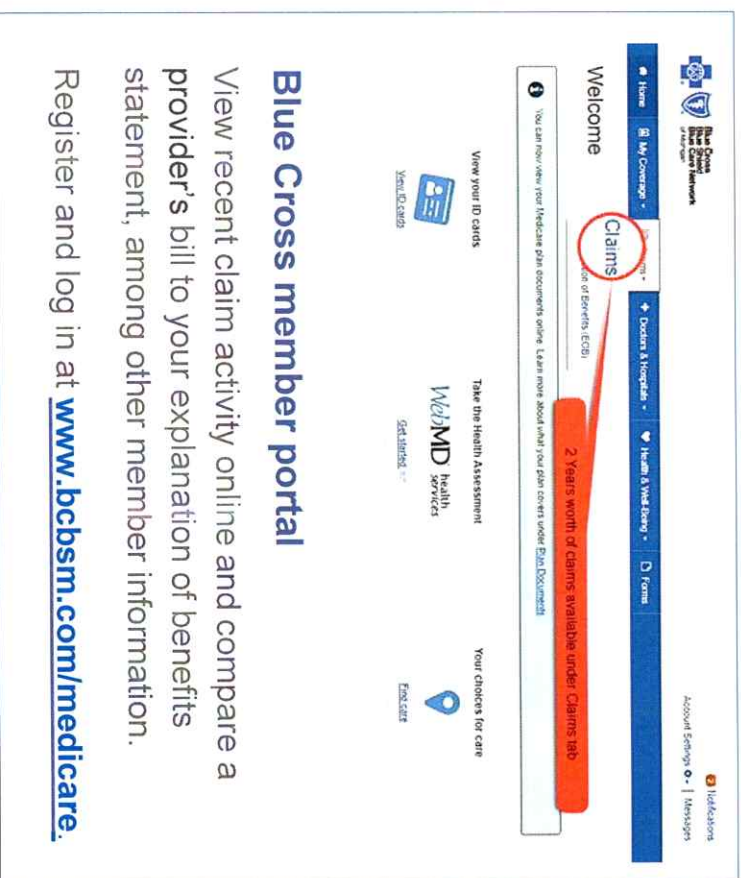
24/7 access to plan information



BCBSM mobile app

You can use the app to:

- Find a participating primary care provider and preferred pharmacies.
- Track costs, check deductibles and out-of-pocket balances.
- Check claims and explanation of benefits statements.
- View your plan coverage.
- View your virtual ID card.

A screenshot of the BCBSM mobile app interface. At the top, there's a navigation bar with icons for Home, My Coverage, Claims, Doctors & Hospitals, Home & Medical, and Forms. The 'Claims' icon is circled in red. Below the navigation bar, there's a 'Welcome' message and a notification: '2 Years worth of claims available under Claims tab'. A red arrow points from the 'Claims' icon to this notification. Below the notification, there are several service tiles: 'View your ID cards' with a 'Virtual ID cards' icon, 'Take the Health Assessment' with a 'WebMD health services' icon, and 'Your choices for care' with an 'EPCAR' icon. At the bottom, there's a footer with 'Account Settings' and 'Messages'.

Blue Cross member portal

View recent claim activity online and compare a provider's bill to your explanation of benefits statement, among other member information.

Register and log in at www.bcbsm.com/medicare.

Prescription drugs





Understanding your pharmacy network

You have access to more than 64,000 pharmacies nationwide, including more than 23,000 preferred pharmacies.*

Nearly all Michigan pharmacies are in our network.

A **network pharmacy** has a contract with Blue Cross to provide your prescription drugs. In most cases, we only pay for prescriptions if they are filled at a network pharmacy.

Preferred: A network pharmacy where you pay lower out-of-pocket costs

Standard: A network pharmacy where you pay standard out-of-pocket costs

Preferred network chain pharmacies*

- Costco
- Meijer
- Sam's Club
- Walmart
- Kroger
- Rite Aid
- Walgreens

We also offer home delivery of your prescriptions through:

Optum Rx Toll-free: 1-855-810-0007 / TTY: 1-800-716-3231

*National Council for Prescription Drug Programs database compared to active participating pharmacies within Optum Network. Optum Rx is an independent company providing home delivery pharmacy services to Blue Cross Blue Shield of Michigan members.

Other pharmacies are available in our network. Look online at www.bcbsm.com/pharmaciesmedicare or in your directory for a complete list.

Your formulary drug tiers



- Your **formulary** is a list of drugs covered by your plan.
- Out-of-pocket cost is applied based on drug tiers and pharmacy type:
 - **Tier 1** = Preferred generic drugs
 - **Tier 2** = Generic
 - **Tier 3** = Preferred brand drugs
 - **Tier 4** = Nonpreferred drugs
 - **Tier 5** = Specialty drugs
- Your plan doesn't have a coverage gap as with other Part D prescription plans. This means you continue to pay your plan's copay until you reach the catastrophic phase. You won't pay anything once you reach the catastrophic phase. Your copay becomes \$0.
- You won't pay more than \$35 for a one-month supply of an insulin product that's included in your health plan's formulary, regardless of the drug tier.

Prescription drugs



	Preferred network pharmacy	Standard network pharmacy	32% to 38-day retail and mail order prescription drug multiplier
Tier 1: Preferred generic drugs	\$3	\$8	Preferred 2x / Standard .75
Tier 2: Non-preferred generic drugs	\$16	\$21	Preferred 2x / Standard 1.5
Tier 3: Preferred brand-name drugs	\$45	\$50	Preferred 2x / Standard 1.8
Tier 4: Non-preferred brand-name drugs	\$95	\$100	Preferred 2x / Standard 1.9
Tier 5: Specialty drugs	29.5%	30%	Supplies greater than 31 days not included

How do I use the drug list?



The drug list shows details about the drugs that are

included in your plan. You can locate your drug in the drug list by **medical condition** or **alphabetically** in the index.

- The first column lists the drugs included in the drug list.
- The Drug Tier column displays the drug's tier, which determines your copay or out-of-pocket cost.
- The third column displays any additional coverage requirements for the drugs (such as prior authorization or quantity limits).
- The bottom of each page includes a key to help you interpret the content.

Drug Name	Drug Tier	Requirements /Limits	Drug Name	Drug Tier	Requirements /Limits
BYDUREON SUBCUTANEOUS SUSPENSION,EXT ENDED REL RECON	3	PA: QL (12 per 84 days)	GLIMEZTA ORAL TABLET, GAST RETENTION 24 HR 500 MG	4	QL (360 per 90 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE,250 MCG(ML) 2.4 ML	4	PA: QL (7.2 per 84 days)	gliburide micronized oral tablet	2	
			gliburide oral tablet	2	

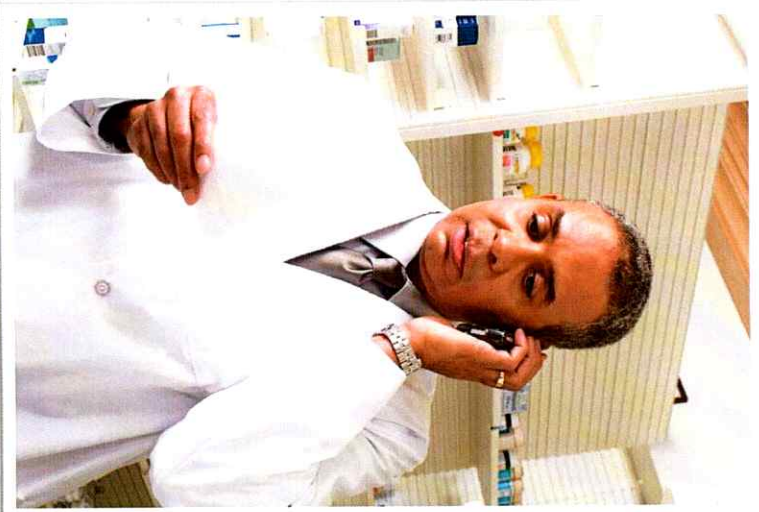
Drug Tier: 1-Preferred Generic 2-Generic 3-Preferred Brand 4-NonPreferred Drug 5-Specialty Drugs
Requirements/Limits: BID - Prior Authorization, Part D vs. Part B only EX - Excluded Drug LA - Limited Availability NEDS - Non-extended Day Supply PA - Prior Authorization QL - Quantity Limit ST - Step Therapy
Brand-name drugs are CAPITALIZED. **Generic** drugs are lower-case italics.

Utilization management



Some covered drugs have additional requirements or limits on coverage, including:

- **Prior authorization:** We complete a safety and effectiveness review for drugs with a PA requirement before coverage is approved.
- **Step therapy:** We require you to first try one drug to treat your medical condition before we'll cover another drug for that condition.
- **Quantity limits:** Only a certain number of doses per prescription or time period may be allowed. Your provider must submit a request for an approval for a higher amount.



Avoiding pharmacy disruptions



We'll do everything possible to minimize disruptions to your prescription drug coverage. We have processes for **drug list exceptions, drug list changes** and **transition prescription fill** to help ensure that you're not without your prescriptions.

Drug list exceptions

When an exception is approved for a drug not on the drug list, you'll pay a Tier 4 (nonpreferred drug) copayment, whether the drug is generic or brand name. Drugs not on the drug list that are approved by a drug list exception **aren't** eligible for tiering exceptions.

Tiering exceptions

You or your provider can ask us to make an exception in the tier for the drug so that you pay less for it. Customer Service can help you request an exception.

Drug list changes

We contact members affected by a drug list change by mail.

Transition prescription fill

During the first 108 days of your plan, you're eligible for a temporary transition fill of Part D-covered medications that aren't on our drug list or are subject to clinical prior authorization, step therapy or drug list quantity limits up to a 31-day supply.

You'll receive a refill of your medication and you and your provider will be notified to contact us to determine future medication needs.

Note: Certain drugs, such as those that may be paid for by Part B or used to treat certain conditions, **aren't** eligible for a temporary supply and will require a prior authorization before you can get the drugs.



Medicare Part B vs. Part D medications

In general, the Part B medical benefit covers:

- Drugs requiring durable medical equipment for administration, such as albuterol through a nebulizer or insulin through an infusion pump
- Immunosuppressive drugs for a Medicare-covered transplant
- Certain oral cancer treatment drugs
- Certain oral drugs for nausea
- Certain vaccines (see list)
- Drugs for kidney failure
- Drugs administered in the provider's office

Medical benefit (Part B) vaccines

- Pneumonia
- Influenza, or flu
- Hepatitis B (high or intermediate risk only)*
- COVID-19

Pharmacy benefit (Part D) vaccines

- Shingles
- Tetanus
- Tetanus/Diphtheria/Pertussis (Tdap)
- Meningitis
- Hepatitis A
- Human papillomavirus (Gardasil)
- Tuberculosis (BCG)

For other vaccines check your drug list for coverage.

*The Hep B Part B vaccine benefit is for members at high or intermediate risk of contracting hepatitis B and requires coverage determination. The Hep A Part D vaccine benefit is for low-risk members, most commonly as a travel vaccine.]

Notice of Late Enrollment Penalty

- A late enrollment penalty is added to your prescription drug plan if you:
 - Didn't enroll in Part D when first eligible
 - Had a break in coverage of 63 days or greater
 - Enrolled in a prescription drug plan that didn't meet Medicare minimum standards for Part D benefits
- The late enrollment penalty is determined by CMS.
- You may receive letters asking to confirm if a penalty is valid; **please respond to the letters.**
- If a penalty is valid, the amount is passed to your group, which will determine if your retiree contribution is increased.

Medicare Plus Blue™ Group PRO
600 E. Lafayette Blvd.
Columbus, OH 43221-2298
bcbsm.com/medicare



<Retiree>
<Address>

<Date>

Beneficiary Notice of Late Enrollment Penalty

Dear <retiree>:

We're writing to tell you that starting <Eff Date> your new premium will include a late enrollment penalty per month.

Your new monthly premium will increase because you didn't have Medicare prescription drug coverage or other drug coverage that met Medicare's minimum standards (creditable coverage).

According to Medicare's records, you didn't have creditable coverage for <# of months> from <date of potential uncovered month> after you were first eligible to sign up for Medicare prescription drug coverage.

If you disagree with your late enrollment penalty, you can ask Medicare to reconsider (review) its decision. Certain circumstances apply to you. For example, you might disagree with the penalty because you had creditable coverage, you had creditable prescription drug coverage or if you didn't get a notice that clearly explained whether you had creditable coverage. A notice explaining your right to a reconsideration of the late enrollment penalty and a reconsideration request form are included with this letter. You must submit your reconsideration request within 60 days of the date on which you received this notice. You should send Part D late enrollment penalty reconsideration request form, if Medicare may not consider your request.

Medicare Plus Blue is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal. You must continue to pay your Medicare Part B premium.

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This form has been reviewed for accuracy and that the information is complete, accurate and consistent with the information on the Blue Cross of Michigan website.

2020-11-19

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Blue Cross Health & Well-Being



SilverSneakers®



Fitness program benefits:

- Membership in a network with thousands of health clubs and exercise locations across the U.S.
- Exercise at your own pace with people in your age group
- Online support to help you lose weight, reduce stress
- Online classes, walking and home fitness programs

SilverSneakers® Tuition Rewards

- SilverSneakers® members can earn college tuition discounts for loved ones simply by exercising



Visit:

- SilverSneakers.com* for participating fitness locations
- SilverSneakers.tuitionrewards.com* to learn about Tuition Rewards

Or call:

1-888-423-4632
Monday through Friday
8 a.m. to 8 p.m. Eastern time
TTY users, call 711

The SilverSneakers shoe logotype is a registered trademark of Twity Health, Inc. © 2023 Twity Health, Inc. All rights reserved. Twity Health is an independent company that provides services to Blue Cross Blue Shield of Michigan Medicare Plus Blue Group PPO members.

*Blue Cross Blue Shield of Michigan doesn't own or control this website.

Blue365®

Blue365 offers exclusive health and wellness deals, keeping you healthy and happy, every day of the year. As a member of Medicare Plus Blue PPO, you automatically have access to nationwide discounts.

Visit: www.blue365deals.com



Blue365
Because health is a big deal™



The Blue365 program is brought to you by the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield plans. Blue365 offers access to savings on items that members may purchase directly from independent vendors, which are different from items that are covered under health care plan policies with Blue Cross Blue Shield of Michigan or Blue Care Network, its contracts with Medicare or any other applicable federal health care program. Neither Blue Cross Blue Shield of Michigan, Blue Care Network nor the Blue Cross and Blue Shield Association recommends, endorses, warrants or guarantees any specific vendor or item.

A screenshot of the Blue365 mobile app interface. At the top, it says "BlueCross BlueShield | Blue365". Below that is a navigation menu with a hamburger icon. The main content area features a large banner for "This Week's Deal... WELLNESS" with the eMindful logo and "EMINDFUL Save 20% on Live Mindfulness Online Classes". Below the banner are three deal cards: "FITNESS THE WEARABLES STORE: BELLAJEY Up to 20% OFF Bluetooth LEAF Nature Health Trackers", "WELLNESS EMINDFUL Save 20% on Live Mindfulness Online Classes", and "PERSONAL CARE TRUHEARING Save 20% to 60% on Hearing Aids". A "See All Deals" link is at the bottom right.

Medicare Advantage Rewards

You work hard to stay on top of your health and wellness. Earn rewards for your annual wellness visit and other healthy activities through Medicare Advantage Rewards.

We'll send you notifications early next year on rewards opportunities for 2024 and how you can take advantage of them.

Home Medicare Plus Medicare 101 Resources Find Care Help

Medicare

Medicare Advantage Rewards

As a Blue Cross Blue Shield of Michigan Medicare Advantage member, it is easy and simple to earn rewards by taking healthy actions, as simple as getting a flu shot. We'll send you a reward!

What is Medicare Advantage Rewards?

This program offers Blue Cross Blue Shield of Michigan Medicare Advantage members gift cards of \$10 or more for taking healthy actions.

How it works

- Step 1** To create and activate your online account, you'll need your Blue Cross member ID card.
- Step 2** Once you've completed your profile, you'll be directed to a list of healthy actions you can take to earn rewards.
- Step 3** For every healthy action you complete, enter the required information in your rewards account and you'll receive your reward.

[ACTIVATE REWARDS ACCOUNT](#)

Ready to sign up?

Blue Cross Coordinated Care



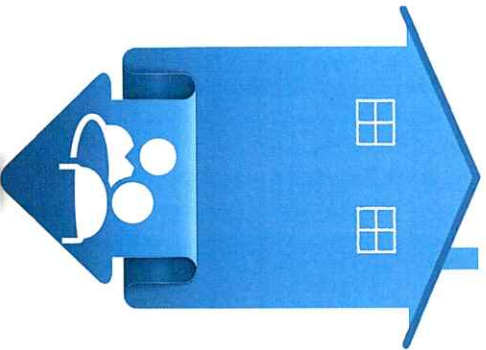
Nurse-led care teams are the backbone for care in our integrated care program. A registered nurse will reach out if you are identified for the Blue Cross Coordinated Care program; a custom care program will be set up to improve your health and well-being.

Registered nurses work directly with you to coordinate the best care to meet your specific needs.

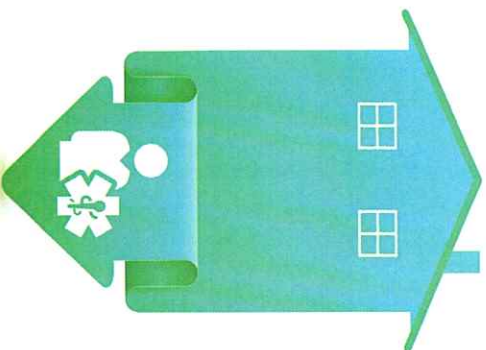
Care teams include:

- **Medical directors** to collaborate with providers and provide medical expertise
- **Pharmacists** to educate and advise you about the right medications
- **Dietitians** to provide targeted nutritional education and coaching
- **Social workers** to address nonmedical health factors and locate community resources
- **Behavioral health specialists** to help with stress, depression, anxiety and other issues

Additional well-being programs



- Advance Care Planning
- Caregiver Support
- Collaborative Care
- Palliative Care



- Meals Delivery
- Non-emergency Medical Transportation
- Virtual Care
- Remote Monitoring



- Diabetes Management
- Supervised Exercise Therapy
- Tobacco Cessation Coaching powered by WebMD®

Call the Blue Cross engagement center for access to these programs



Our knowledgeable specialists are here to answer your questions about any of the programs or services offered through Blue Cross Health & Well-Being.

We can help:

- Coordinate program referrals
- Connect you with a nurse care manager

Engagement Center

Monday through Friday 8 a.m. to 4:30 p.m. Eastern time

1-800-775-BLUE (2583)

All calls are toll-free and strictly confidential



Customer Service



Customer Service can help

- Confirm out-of-pocket costs
- Answer personal account questions
- Order a new Blue Cross ID card

- Locate a provider
- Assist with benefit questions
- Discuss claims

1-866-684-8216

Oct. 1 through March 31

Seven days a week

8 a.m. to 9 p.m. Eastern time

April 1 through Sept. 30

Monday through Friday

8:30 a.m. to 5 p.m. Eastern time

TTY users, call 711



How do I enroll?



If you would like to enroll into the BCBSM MAPD PPO plan, you will have to go through an enrollment process:

- Online at www.bcbsmgroupprovider.com
- Telephonically by calling **1-800-284-6994 (TTY:711)**

OR

- If you received a paper application in the mail, you will need to complete this form and return it in the enclosed envelope.

If you have any questions, please contact **TMR & Associates** at (313)963-1135

Or Visit: www.tmrassoc.com/wayne-county-retirees/

Enrollment Tips



- You can only be enrolled in ONE Medicare Advantage plan or PDP plan at a time
- If you choose to enroll in the BCBSM MAPD PPO plan, any other Medicare Advantage coverage that you have will be canceled
- If you are enrolled in another Retiree Group Medicare Advantage plan, please check with the Employer Group before you enroll in the BCBSM MAPD PPO plan
- If you elect this plan and you currently have a Medicare Supplement plan, you want to make sure you cancel the Medicare Supplement plan and stop paying that premium

Billing



- You will receive a bill directly from BCBSM
- Once you receive your first bill, you must pay it directly to BCBSM
- Once your first bill is paid, you may contact the Customer Service department at **1-866-684-8216** to set-up automatic, recurring payment

Thank you for coming.

Blue Cross
of Michigan



Our commitment to you:

We work for you.

We strive to be clear and simple so we can help you understand and use your plan. Blue Cross provides the right access and improved care for you and your loved ones, proactively guiding you to **Smarter, Better Healthcare.**





Questions?

We're here to help

